EDITORIALS

The Difficult Plight of Self-Employed Physicians

THE CHANGING ECONOMICS of medical practice and patient care is creating many new problems for self-employed physicians, most of whom see and treat their patients on a fee-for-service basis. When fees for service were simply a matter between physician and patient the problems were few. The fee charged related both to the skill and reputation of the physician and a patient's ability to pay. There were occasional problems with excessive charges by physicians and some inequities. However, by and large the system worked well, and provided for a wide variation in the ability of patients to pay for physicians' services—and most physicians never became wealthy.

The advent of health insurance introduced a third party into the fiscal relationship between doctor and patient. When a patient had health insurance coverage, a third party, the health insurance carrier, paid all or part of the bill and the amount and appropriateness of the physician's fee became a concern of others, that is, the insurance carrier when the money came from the private sector, or the government when it was paying the bill in a public program. As this happened it became necessary to find a way to provide the third party payors with some guidance as to what might be an appropriate fee and what might not. The solutions to this were the relative value studies and the concept of usual, customary and reasonable (UCR) fees. Both were based on the actual going rates for physicians' fees in various specialties and differing geographic areas. Provision was made for peer review and for payment of fees outside the norm by documentation of special circumstances. This worked well for a number of years, and met the needs of third party payors for guidance regarding payments, while preserving the individual self-employed physician's right to determine his or her own fees and to adjust them as necessary to rising costs or changing circumstances.

More recently the pressures on this system have been growing. Certain inequities have developed within it, and there has been some misuse, particularly when excessively high fees are charged for some of the newer procedures. Also, both government and industry are focusing more attention on physicians' fees because they pay most of them. As costs rise both are beginning to seek new means of negotiating or controlling physicians' fees as well as other costs of patient care.

Self-employed physicians now find themselves in a difficult plight. In a sense they are surrounded on all sides with no obvious way out. On the left flank, if you will, are government programs which involve fixed-fee schedules (which are apt to be inadequate) or other means to control or contain physicians' fees. On the right flank, employers in the private sector are similarly trying to develop contractual arrangements for the purchase of health care services that will control costs including physicians' fees. To the rear, the basic support of the relative value studies has been weakened if not destroyed by actions of the Federal Trade Commission, and the UCR concept is no longer working as well as it did. And the road ahead seems blocked because the labor laws are not designed to serve workers who are not in an employer-employee relationship, and any effort to act collectively outside of the protection of these labor laws is restrained by antitrust laws.

The plight seems real enough. Those who fi-

nance the greatest part of medical care, whether in government, business or industry, are possessed of economic leverage which is potentially enormous compared with that of self-employed physicians (or other self-employed professionals for that matter) who find themselves disadvantaged because there is no employer with whom they can negotiate collectively under the law. This writer believes that the time has come for new legislation that will recognize the plight of self-employed professionals, who need to be able to negotiate collectively through their professional organizations with those who actually pay for the services that these professionals render to patients or clients who have public entitlement or other third party fiscal coverage for such services. This legislation would not only be fair, but, surely, in the long range, in the public's interest as well.

—MSMW

Therapy for Acromegaly, Cushing Disease and Nelson Syndrome

THE PAPER BY Lawrence and Linfoot elsewhere in this issue, describing the effects of proton beam therapy in the treatment of acromegaly, Cushing* disease, and Nelson syndrome in 429 patients with various pituitary neoplasms, is the largest series available on the use of this technique. One of the major difficulties in determining the efficacy of therapy used in the treatment of relatively uncommon conditions such as these is the lack of availability of a large enough series of patients followed carefully for a long enough time. This study of acromegaly and of Cushing disease used a highly significant number of patients. Unfortunately, for an adequate scientific evaluation, it was not possible to follow a similar control group. The authors do present data which indicate that survival of patients with acromegaly is substantially decreased compared with the expected survival of an age-matched population. The question that cannot be answered from these data is how different the treated group may be from a non-treated group. The data presented are incomplete; for example, growth hormone levels are given for only 124 of 208 patients with acromegaly who were said to have been treated. It would be helpful if data were available to indicate whether survival was greater among those with normal growth hormone levels after therapy. Are the 10 percent who died during the course of the study those patients in whom the human growth hormone (HGH) levels were not adequately lowered by the procedure? It is of interest that there are few elevated HGH levels noted after about six years in the groups presented in their Figures 3 and 4. Was this due to continued action of the therapy over a relatively long time or the result of the death of those patients in whom levels of growth hormone had remained elevated?

There are several reports of smaller series using the alternative therapy for acromegaly, transsphenoidal pituitary surgical excision. In one recent report an adenoma was identified and removed in 27 of 28 patients; in 14 of 15 patients who were not cured by the procedure extrasellar extension had occurred.[1] In another study 16 patients underwent transsphenoidal operations for acromegaly, with satisfactory results in 12 who were followed for an average of 24 months. Failure was attributed to the possibility of locally invasive adenomas. Two patients required a second operation.[2] The authors of both of these studies concluded that transsphenoidal surgical excision is effective in the treatment of acromegaly. A third report describes 80 patients with acromegaly who had had this operation and whose cases had been followed for an average of 3.7 years. Complete regression or improvement occurred in 94 percent of the patients and tumors recurred in 5 percent. The mortality during the follow-up period was 7.5 percent.[3] From these data we must conclude that pituitary microsurgical operations for acromegaly, although effective in most cases, leave a significant number not cured.

The data presented on the treatment of Cushing disease by proton beam irradiation indicate that better survival rates occurred than were found with acromegaly. Treatment by transsphenoidal pituitary microsurgical procedures in two studies resulted in successful removal of adenomas from 16 of 18 and 17 of 20 patients; however, the follow-up period was relatively short.[4,5] In another recent review, experience with transsphenoidal pituitary microsurgical procedures for this

*THE WESTERN JOURNAL'S style regarding eponyms is that they are not written in the possessive form; therefore, Graves disease, Ewing sarcoma and Paget disease. A explanation may be found on page 78 of the July 1978 issue.